Beach Dental
STUDIO

FINANCIAL POLICY AND PROCEDURE

1. I understand that payment is due at the time that the services are rendered.
2. Our office accepts Cash, Check, Credit Cards and CareCredit.
3. Patients who file insurance are expected to pay *estimated* portions at the time serves are rendered.
4. I understand that dental insurance claims will be submitted as a courtesy to our patients. We will make every effort to make sure your claim is filed accurately and timely. If the patient has not provided the proper information and paperwork no claim can be filed. Patients are responsible to inform our office of any changes to their insurance carrier or policy. We will submit for pre-treatment estimates for major services to determine your insurance benefits upon request. If your insurance company denies your claim we expect payment of the full balance within 10 days of the notice you receive from your insurance company. Our professional services are rendered to the patient and not to the insurance company. Treatment is based on patient need and not insurance company benefits. We cannot render services to the patient based on the assumption that the charges will be paid by the insurance company, nor can we know every service not covered by your insurance company. It is the patient's responsibility to be involved with their own insurance company. The patient is responsible for their entire bill regardless of insurance benefits.
5. I understand the Beach Dental Studio charges a service fee of 18% annually (1.5% monthly) on outstanding account balances 60 days or more.
6. I understand that there is a handling fee of $35.00 for all returned checks.
7. I agree to pay any attorney, collection, or court fees associated with collection of delinquent accounts.
8. I agree to follow the Broken Appointment Policy which includes a fee of $35.00 per half hour for appointments canceled for any reason without 24 hours notice. I understand that this time has been reserved specifically for me.

Our goal is to provide you with a high quality dental experience. If we can be of any assistance please feel free to ask. We deeply appreciate your loyalty and encourage you to refer your friends and family.

I have read and understand this financial policy and realize that payment is my responsibility._____(initials)

I authorize the release of any information and/or x-rays relating to my dental treatment to the insurance company, attorney, or collection agency in collecting the full cost of services rendered to myself and my family._____(initials)

I authorize the release of my dental records to the offices that I have been referred._____(initials)

I have received a copy of the HIPPA privacy policy. _____(initials)

I have received a copy of the broken Appointment Policy_____(initials)

_____	_____	_____
Name (printed)	**Signature**	**Date**